Huron Valley Consultation Center
Ann Arbor, Michigan

CHILD INTAKE INFORMATION

Intake Date ___________________ Case #_______________

Patient Name: ____

Address: ____
Street City State Zip

Parents: _____________________________ _______ ________________________________ _______
Mother Age Father Age

Parent's Address if different: ____

Phone (Home): (____)___________________________ Parent's (Work): (_____)________________
Father
(_____)________________
Mother

Date of Birth: _________________________________Age: _______ Sex: _______
School:____ Grade: _______

Father's Present Employer/Address: ____
Occupation: ____
Education: ____ Driver's License #: _________________

Mother's Present Employer/Address: ____
Occupation: ____
Education: ____ Driver's License #: _________________

Names/Ages/Sex of Siblings. Please indicate if any siblings reside in other that the child's residence.

______________________________ ______ ______ ___________________________ _____ ____
______________________________ ______ ______ ___________________________ _____ ____
______________________________ ______ ______ ___________________________ _____ ____

Form of Payment: Insurance____Cash_________
Contract #: _________________________________ Group #: ___________________________________
Policy Holder's Name: _______________________________________DOB:_____________________
Relationship to patient: ________________________

Secondary Insurance___________________________________ Contract #: _________________________
Group #: ___________________________________
Policy Holder's Name: _______________________________________DOB:_____________________
Relationship to patient: ________________________

****FOR STAFF USE ONLY****

____ _______________________
**DSM-V/ICD-10 Code

____ _______________________
Therapist Signature Therapist Code
Print Name:____

Insurance	**Deductible**	**Copay**	**Yearly maximum**	**Lifetime max**
Primary				
Secondary				

If applicable:
Authorization #:__________________________Number of sessions:________Dates covered:________________________

Rev. 2/2018

Please briefly state why this child was brought to the clinic. What are your concerns?

____

____

Has your child been seen by any other persons for this problem? Please explain.____________________

____

____

Education and School History

Please provide the following information for all schools that the child has attended:

School	Year started	Year stopped	Graduated?

What is your child's attitude about school? About the teacher(s)? About other students?_____________

____

____

How would you describe your child's performance and behavior at school? Are there any problems?

____

____

Financial Status

Family's overall financial status (including gross annual income, major assets/liabilities, number of dependents, etc.):____

____

Developmental History

How would you describe the pregnancy with this child?____

____

Were there complications? If so, explain:____

____

Birth weight:___________________________________

Were there any difficulties in infancy with (please circle):

Feeding	Yes	No
Weight gain	Yes	No
Sleeping	Yes	No
Weaning from breast/bottle	Yes	No
Crying	Yes	No

When did your child first (age):

Sit	_______________________
Walk	_______________________
Say a word	_______________________
Say simple sentences	_______________________

Describe and give age of any significant illnesses, including ear infections, high fevers, operations, and/or accidental injuries:____

____

Describe any problem behaviors or personality difficulties as a preschooler:________________________

____

Has your child had any traumatic or potentially traumatic experiences? If so, explain:________________

____

During the past year, have there been any significant events which might have had a negative effect on your child? If so, explain.____

____

Legal Problems

Does the family have any pending legal problems? Yes No
Have you had prior legal problems in any way associated with your seeking treatment for your child at this time? Yes No
If yes to either of the above, please explain:____

____

Culture, Ethic, and Religious Information

Does your family or your child currently, or have you or your child in the past, practiced a particular religion?
Yes No

If yes, please provide additional information about the religion, your current level of involvement, and your anticipated interest in this in the future:____

____

Does your family identify with particular cultural or ethnic groups? Of what overall importance is this in your family's life?____

____

Present Family Constellation

Please list any other persons living with the family:_______________________________________

____

Have there been any significant separation, divorces, deaths, etc., in the child's life?_____________

____

____

Activity Assessment

Approximately how much time does your child spend on play and leisure activities on a typical week day?
_____________________ hours per day.

Approximately how much time does your child spend on play and leisure activities on a typical weekend (Saturday and Sunday?) _____________________ hours per day.

Is the amount of leisure time your child has available (check one):

Less than adequate______ Adequate_______ More than adequate_______ Much too much_________

With regards to the ways your child spends leisure time, would you say your child is (check one):

Very dissatisfied _____ Less than satisfied_____ Satisfied_____ More than satisfied______Very satisfied_______

Please list the activities in which your child is most active, starting with the activity in which he/she spends the most time? Include activities such as homework, individual or group play, chores, church activities, watching TV, computer, household projects, etc.)

Activity	**Approximate number of hours per week**
1.	
2.	
3.	
4.	
5.	
6.	

Are there activities you would like to see your child involved in? _________________________________

____

Are there activities your child has expressed interest in, but is not presently involved in?______________

____

Medical History

Name, address, and phone number of current or most recent medical doctor:________________________

____

What was the date of your child's last physical examination? ___________________________________

Height:___________________________ Weight:________________________

Please list all current medications:

Name of medication	Dose	Frequency taken	How long taken	Who prescribes

Please check "yes" or "no" to indicate whether or not your child uses the following non-medical or non-prescribed drugs. For "yes" answers, please indicate usage:

	Yes	No	How much	How long
Cigarettes				
Sleeping pills				
Tobacco				
Alcohol				
Marijuana				
Cocaine, crack				
Inhalants				
Stimulants (e.g., "uppers")				
Aspirin or other pain medication				
Cold remedies, cough medicine				
Coffee				
Tea				
Cola				
Other:				

Does your child have physical pain? Yes_____No_____
If yes, rate the intensity of the pain: 1(mild) to 5 (severe): ____________.
If yes, where is the pain located: ____.
If yes, how does it impact your child's functioning?____________________________________

Does your child have any allergies, including food allergies? If yes, explain:_______________________

____ .

Please check either “yes” or “no” to indicate whether or not the family has any of the following health problems. (Any unanswered questions will be considered a “no” response.)

	Child	**Mother**	**Father**	**Siblings**	**Extended family member**
Seizure disorder/epilepsy					
Glaucoma					
Emphysema					
Asthma					
Heart trouble					
High blood pressure					
Stomach trouble/ulcers					
Tuberculosis					
Thyroid disease					
Liver disease					
Gall bladder					
Hepatitis					
Diabetes					
Pancreatitis					
Cancer or tumor					
Arthritis or rheumatism					
Alcohol and/or drug abuse					
Stroke					
Anemia					
Depression					
Anxiety					
Mania or bipolar disorder					
Schizophrenia					
Learning disorder					
Attention deficit/hyperactivity disorder					
Other					
Other:					

Is there any other medical, psychiatric, or substance abuse information that you feel we should know?

____

____

Is there anything else that you think we should know about your child or your family?_________________

____

Signature:

____ ____________________________

Parent/guardian Date

For therapist use only:
If it has been over a year since the child/adolescent’s last physical, did you suggest that the child/adolescent have a physical? Yes_____ No_____Did the parent/guardian agree to this? Yes_____ No______

Therapist signature:_______________________________________ Date: _______________________

Child/Adolescent Symptom Checklist

Name:_________________________________**Age:**__________**Date:**____________________

Name of the person completing this form:______________________**Relationship to child:**______________________

Instructions: The questions below ask about things that might have bothered your child. For each word or phrase, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

During the past **TWO (2) WEEKS,** how often has your child been bothered by:	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
Hyperactivity	0	1	2	3	4
Being fidgety	0	1	2	3	4
Difficulty sitting still	0	1	2	3	4
Being easily distracted	0	1	2	3	4
Forgetting easily	0	1	2	3	4
Not turning in assignments	0	1	2	3	4
Being disorganized	0	1	2	3	4
Poor grades	0	1	2	3	4
Academically behind	0	1	2	3	4
Learning difficulty	0	1	2	3	4
Speech problems	0	1	2	3	4
Reading difficulty	0	1	2	3	4
Math difficulty	0	1	2	3	4
Defying authority	0	1	2	3	4
Losing temper	0	1	2	3	4
Being argumentative	0	1	2	3	4
Getting angry easily	0	1	2	3	4
Getting into fights	0	1	2	3	4
Throwing or breaking objects	0	1	2	3	4
Problems with temper	0	1	2	3	4
Hurting animals	0	1	2	3	4
Lying	0	1	2	3	4
Setting fires	0	1	2	3	4
Stealing, shoplifting	0	1	2	3	4
Breaking curfew	0	1	2	3	4
Running away from home	0	1	2	3	4
Skipping school	0	1	2	3	4
Legal problems	0	1	2	3	4
Is or has been on probation	0	1	2	3	4
Is or was in juvenile detention	0	1	2	3	4
Problem making or keeping friends	0	1	2	3	4

Suicidal thoughts, present	□ Yes	□ No
Suicidal thoughts, past	□ Yes	□ No
Suicide attempt or gesture	□ Yes	□ No
Homicidal thoughts	□ Yes	□ No

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Name:___________________________________**Age:**__________**Date:**_____________________

During the past **TWO (2) WEEKS,** how often has your child been bothered by:	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day
Loss of appetite	0	1	2	3	4
Dental problems	0	1	2	3	4
Eating disorder	0	1	2	3	4
Picky eater	0	1	2	3	4
Binge-eating, purging	0	1	2	3	4
Anorexia	0	1	2	3	4
Weight loss or gain	0	1	2	3	4
If so, how much in the last 3 months:					
Gained:_______Lost:_______					
Difficulty separating	0	1	2	3	4
Won't sleep in own bed	0	1	2	3	4
Night terrors	0	1	2	3	4
Fears of ordinary things For example: crowds, storms, doctor, germs, flying, closed spaces	0	1	2	3	4
Panic/anxiety attacks	0	1	2	3	4
Suspiciousness, paranoia	0	1	2	3	4
Wets bed	0	1	2	3	4
Soils underclothing	0	1	2	3	4
Oversleeping	0	1	2	3	4
Mood swings	0	1	2	3	4
Crying spells	0	1	2	3	4
Low energy, tired	0	1	2	3	4
Trauma, other abuse	0	1	2	3	4

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 11–17

Name: _______________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**___________

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) have you…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Been bothered by stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Worried about your health or about getting sick?	0	1	2	3	4	
II.	3.	Been bothered by not being able to fall asleep or stay asleep, or by waking up too early?	0	1	2	3	4	
III.	4.	Been bothered by not being able to pay attention when you were in class or doing homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than you used to?	0	1	2	3	4	
	6.	Felt sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Felt more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Felt angry or lost your temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or done more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual but still had a lot of energy?	0	1	2	3	4	
VIII.	11.	Felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Not been able to do things you wanted to or should have done, because they made you feel nervous?	0	1	2	3	4	
IX.	14.	Heard voices—when there was no one there—speaking about you or telling you what to do or saying bad things to you?	0	1	2	3	4	
	15.	Had visions when you were completely awake—that is, seen something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Had thoughts that kept coming into your mind that you would do something bad or that something bad would happen to you or to someone else?	0	1	2	3	4	
	17.	Felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Worried a lot about things you touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Felt you had to do things in a certain way, like counting or saying special things, to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** have you…						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes			☐ No		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes			☐ No		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like Ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes			☐ No		
	23.	Used any medicine without a doctor's prescription to get high or change the way you feel (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes			☐ No		
XII.	24.	In the last 2 weeks, have you thought about killing yourself or committing suicide?	☐ Yes			☐ No		
	25.	Have you EVER tried to kill yourself?	☐ Yes			☐ No		

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DSM-5 Parent/Guardian-Rated Level 1 Cross-Cutting Symptom Measure—Child Age 6–17

Child's Name: ______________________________ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**___________

Relationship with the child: ____

Instructions *(to the parent or guardian of child):* The questions below ask about things that might have bothered your child. For each question, circle the number that best describes how much (or how often) your child has been bothered by each problem during the **past TWO (2) WEEKS.**

		During the past **TWO (2) WEEKS,** how much (or how often) has your child…	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1.	Complained of stomachaches, headaches, or other aches and pains?	0	1	2	3	4	
	2.	Said he/she was worried about his/her health or about getting sick?	0	1	2	3	4	
II.	3.	Had problems sleeping—that is, trouble falling asleep, staying asleep, or waking up too early?	0	1	2	3	4	
III.	4.	Had problems paying attention when he/she was in class or doing his/her homework or reading a book or playing a game?	0	1	2	3	4	
IV.	5.	Had less fun doing things than he/she used to?	0	1	2	3	4	
	6.	Seemed sad or depressed for several hours?	0	1	2	3	4	
V. & VI.	7.	Seemed more irritated or easily annoyed than usual?	0	1	2	3	4	
	8.	Seemed angry or lost his/her temper?	0	1	2	3	4	
VII.	9.	Started lots more projects than usual or did more risky things than usual?	0	1	2	3	4	
	10.	Slept less than usual for him/her, but still had lots of energy?	0	1	2	3	4	
VIII.	11.	Said he/she felt nervous, anxious, or scared?	0	1	2	3	4	
	12.	Not been able to stop worrying?	0	1	2	3	4	
	13.	Said he/she couldn't do things he/she wanted to or should have done, because they made him/her feel nervous?	0	1	2	3	4	
IX.	14.	Said that he/she heard voices—when there was no one there—speaking about him/her or telling him/her what to do or saying bad things to him/her?	0	1	2	3	4	
	15.	Said that he/she had a vision when he/she was completely awake—that is, saw something or someone that no one else could see?	0	1	2	3	4	
X.	16.	Said that he/she had thoughts that kept coming into his/her mind that he/she would do something bad or that something bad would happen to him/her or to someone else?	0	1	2	3	4	
	17.	Said he/she felt the need to check on certain things over and over again, like whether a door was locked or whether the stove was turned off?	0	1	2	3	4	
	18.	Seemed to worry a lot about things he/she touched being dirty or having germs or being poisoned?	0	1	2	3	4	
	19.	Said that he/she had to do things in a certain way, like counting or saying special things out loud, in order to keep something bad from happening?	0	1	2	3	4	
		In the past **TWO (2) WEEKS,** has your child …						
XI.	20.	Had an alcoholic beverage (beer, wine, liquor, etc.)?	☐ Yes		☐ No	☐ Don't Know		
	21.	Smoked a cigarette, a cigar, or pipe, or used snuff or chewing tobacco?	☐ Yes		☐ No	☐ Don't Know		
	22.	Used drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)?	☐ Yes		☐ No	☐ Don't Know		
	23.	Used any medicine without a doctor's prescription (e.g., painkillers [like Vicodin], stimulants [like Ritalin or Adderall], sedatives or tranquilizers [like sleeping pills or Valium], or steroids)?	☐ Yes		☐ No	☐ Don't Know		
XII.	24.	In the past **TWO (2) WEEKS,** has he/she talked about wanting to kill himself/herself or about wanting to commit suicide?	☐ Yes		☐ No	☐ Don't Know		
	25.	Has he/she EVER tried to kill himself/herself?	☐ Yes		☐ No	☐ Don't Know		

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